

GOOD PRACTICE BRIEF

HEALTH PROMOTION CENTRES IN SLOVENIA: Integrating population and individual services to reduce health inequalities at community level

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Summary

Health promotion centres (HPCs) were created in 2002 in all 61 primary health care (PHC) centres across Slovenia. Their main role was to provide lifestyle interventions against key risk factors for noncommunicable diseases (NCDs) by combining population and individual approaches. HPCs integrated previously dispersed activities in PHC centres, including community nursing. Between 2013 and 2016, a new paradigm was piloted to assure integration of different services targeting vulnerable groups. The new role of HPCs was to create partnerships with key stakeholders, including social services and nongovernmental organizations (NGOs), to improve health at community level. Health promotion teams were established to prepare local strategies and actions plans, which would address the needs of different population groups and identify and reduce health inequalities.

Persistent health inequalities – a vexing public health challenge

Despite universal and comprehensive health care access for all Slovenian citizens and the health improvements achieved in the last few decades, Slovenia faces persistent inequalities in NCD outcomes across regions. Western and central regions are much better off than the eastern and north-eastern regions, reflecting different levels of development and poverty (1). Moreover, differences in health system response to the needs of vulnerable population groups hamper their access to health services, including preventive services, due to health illiteracy, poverty and unemployment. Inequalities exist between genders with regard to health status and access and use of medical services. Health inequalities begin early in the life course and have increased among schoolchildren, in particular, among those from lower socioeconomic classes. As in other European countries, the economic and financial crisis has deepened health inequalities in Slovenia (Fig. 1 and Fig. 2).

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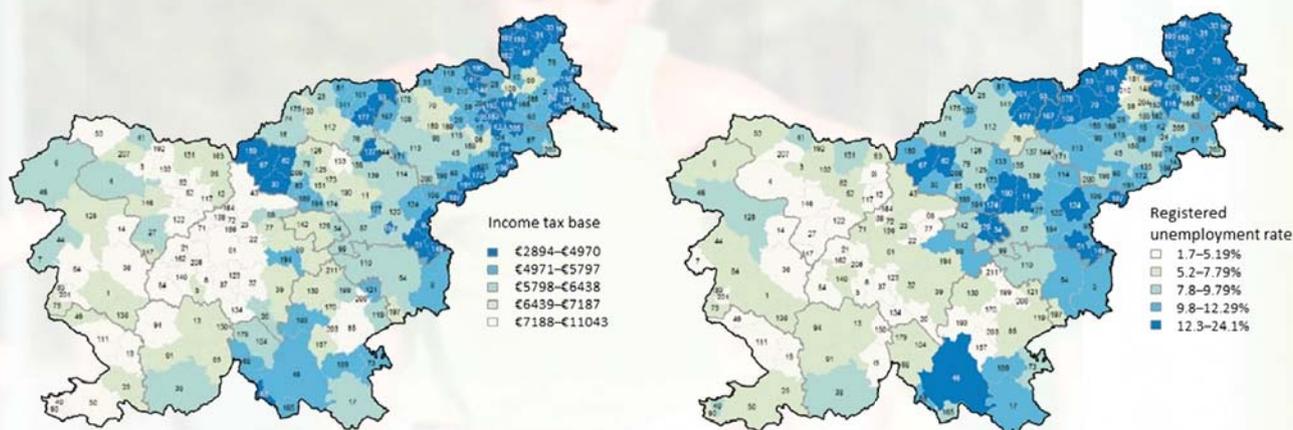
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Key Messages

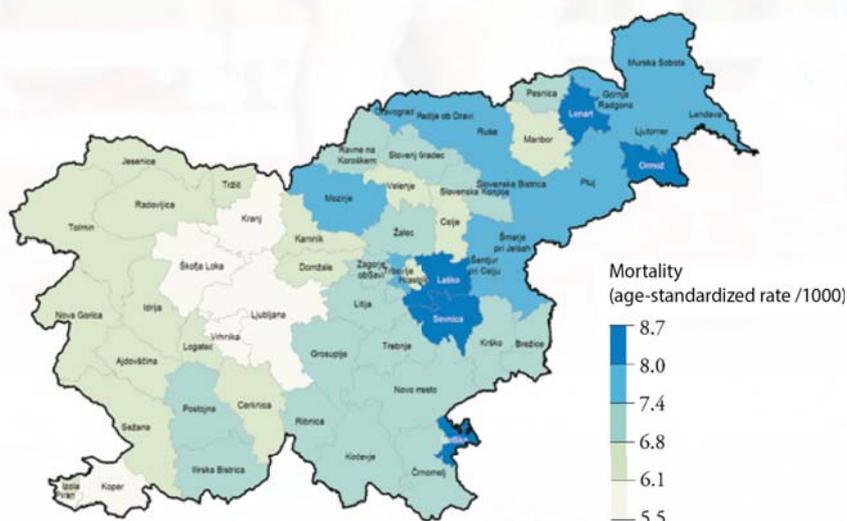
- The health system has played a leading role in reducing health inequalities, particularly for NCDs, in Slovenia.
- A contextualized community-based approach enables a prompt and structured response to the needs of vulnerable populations.
- An integrated multidisciplinary approach requires transforming service delivery so governance, funding and competencies are aligned.
- Multidisciplinary teams in HPCs have a broad spectrum of competencies and skills to provide health promotion and disease prevention programmes within PHC.
- Cross-sectoral cooperation based on a community-based approach is of crucial importance for health equity.
- Assuring sustainable financing for health promotion and disease prevention is essential.

Fig. 1. Distribution of Slovenian municipalities into quintiles relative to income tax base per capita and registered unemployment rate, 2004–2008



Source: Tax Administration of the Republic of Slovenia (TARS), 2004–2008 (recalculations by the Institute of Macroeconomic Analysis and Development of the Republic of Slovenia); Surveying and Mapping Authority of the Republic of Slovenia (SMARS), 2010.

Fig. 2. Mortality by Slovenian administrative units, 2005–2009



Source: National Institute of Public Health (NIPH) Database of deaths 2005–2009; SMARS.

Triggered by the report on health inequalities in Slovenia from 2011 (2) and a thorough analysis of the health system performed in 2015 (3), Parliament adopted the decision to better address the needs of vulnerable populations and to reduce inequalities by strengthening PHC capacities. To assure a community-based approach that focuses on health determinants, health promotion and prevention of NCDs, steps were undertaken to strengthen HPCs as an integral part of PHC, which integrate primary care and public health services and engage with other sectors and stakeholders.

Strengthening PHC to reduce inequalities in health at community level: HPCs

PHC has a long tradition in Slovenia and presents the first point of contact for patients, with good access to curative and preventive services. With a wide range of practitioners providing health care at primary level (general practitioners (GPs), paediatricians, gynaecologists, community nurses, midwives, dentists for adults and children, pharmacists, physical therapists, psychologists and other health professionals), it has a gate-keeping role in the health system.

Phase 1. Strengthen systems for health promotion and disease prevention for the entire population.

In 2002, a few months after Slovenia adopted its national programme for the prevention of cardiovascular diseases (CVD Preventive Programme), HPCs were introduced into the existing strong PHC network (61 PHC centres). GP practices were tasked to provide preventive check-ups and refer patients at risk to HPCs for fee-free lifestyle intervention classes.

The National Health Insurance Fund (NHIF) provided funding, and financial incentives were introduced for GP practices who reach target values for preventive check-ups. At the same time, the introduction of HPCs represented an opportunity to employ more nurses and other health promotion professionals, and an incentive for the management of PHC centres to expand their task profile and service baskets.

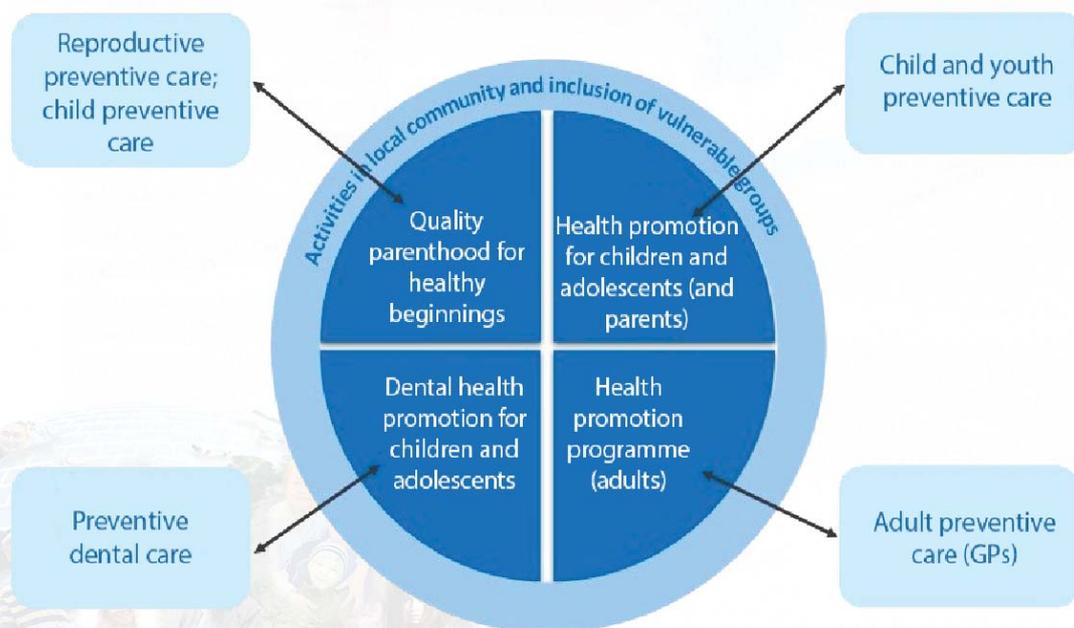
Implementation of the CVD Preventive Programme was first managed by CINDI Slovenia (a WHO Countrywide NCD Intervention programme led by one of the biggest PHC centres in Ljubljana), and later by the NIPH. Programme management included the development of interventions, training and follow-up of professional development, implementation and process evaluation.

Phase 2. Strengthen the focus on inequalities and vulnerable groups.

A new initiative to upgrade the existing HPCs started in 2013 (4). Using the Norwegian Funding Mechanism, a project "Towards better health and reducing inequalities in health" was piloted in three PHC centres in different parts of Slovenia. Within this project, 2.2 million euros were invested to address the widening gap of inequalities, including in health, by reducing lifestyle-related chronic NCDs. Based on an assessment, the CVD Preventive Programme was adapted to meet the needs of vulnerable populations (children, adolescents and adults).

Upgraded HPCs (Fig. 3) include multidisciplinary teams of nurses, physiotherapists, psychologists, dieticians and kinesiologists. Patients attend individual and group classes on lifestyle changes regarding healthy nutrition, physical activity and mental health; smoking, alcohol use, obesity and diabetes are addressed as well.

Fig. 3. Integrated HPC



Within the project, several tools were developed to support the work of professionals in HPCs, including guidelines, protocols and models for comprehensive prevention of NCDs related to lifestyle factors and for the integration of preventive services. Training materials to address cultural differences and develop competences in intercultural mediation were also prepared.

More than 60 experts from the NIPH contributed to the project, and more than 100 other professionals were involved, including family doctors, nurses and midwives, anthropologists, sociologists, clinical psychologists and dieticians. Social work centres, schools, employment services, NGOs and other stakeholders at community level contributed to the development of this new approach.

The three HPCs in pilot PHC centres became the cornerstone and the driver to establish contact with the most vulnerable and hard-to-reach populations and to integrate different structures, professionals and programmes within PHC centres and the community.

Apart from the health promotion teams in HPCs at community level, health promotion action groups were established to help identify and include hard-to-reach populations (unemployed, Roma population, people with mental health problems or disabilities, illicit drug users and others) in the new preventive programme.

The pilot project concluded in 2016 with plans to introduce the new model into at least 25 additional HPCs by 2020. The Government of Slovenia assigned an additional 15 million euros from the European Union cohesion funds for this purpose (5).

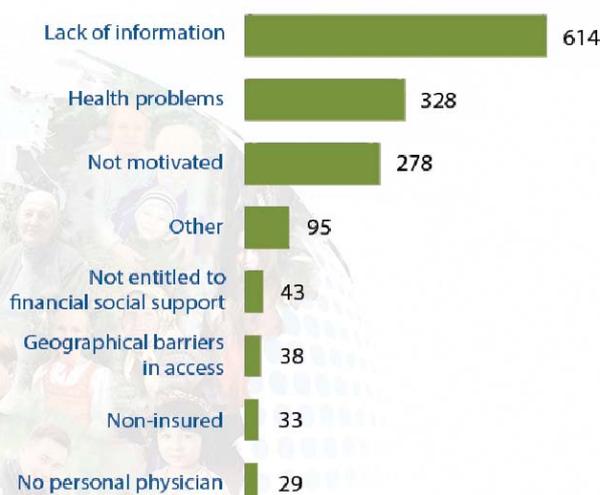
Impact

In the 15 years of operating HPCs and implementing the CVD Preventive Programme, more than half of the adult population was screened for lifestyle risk factors. Almost 50 000 patients annually attend intervention classes in HPCs. Trends in (premature) mortality, particularly for cardiovascular disease, declined by 19% between 2007 and 2015 (from 327 to 266 per 100 000). However, disparities still exist between regions, as well as between income categories.

The initial scepticism of GPs and other health professionals about the contents, target values and financing of the programme gradually changed to enthusiasm due to improved patient health outcomes.

As part of the project "Towards better health and reducing inequalities in health", NIPH performed a field survey in three piloted communities to identify key vulnerable groups and their barriers in access to care. A total of 850 people participated in the survey including people with socioeconomic vulnerabilities, mental health disorders and disabilities; the unemployed; the homeless; and other vulnerable groups. They identified perceived barriers to preventive interventions (Fig. 4). To address these access barriers, a wide range of stakeholders in partnership performed interventions targeting people from different vulnerable groups (Fig. 5).

Fig. 4. Number of people and perceived barriers to preventive services



Note: survey responders could choose multiple barriers.

Source: NIPH.

Fig. 5. Number of stakeholders engaging in action to address access barriers



Source: NIPH.

Implications for policy

The National Health Care Plan 2016–2025, which prioritizes equal rights and access to health services as core values for the development of Slovenia's health system, guarantees the sustainability of the achievements. The HPCs and the new model for health promotion and disease prevention will be systematically scaled up to all PHC centres:

- through fully integrating financing within compulsory health insurance by increasing capitation payments and incentivizing performance of preventive services; and
- by systematically incorporating capacity-building activities developed under these programmes into the educational programmes of health and other professionals.

The next phase will emphasize working in the community by providing support to local initiatives and approaches. Thus, NIPH, PHC centres and municipality administration will steer the process of establishing a local action group for health promotion by using a community approach to identify local health needs and build solutions.

Lessons learned

- **The health system has played a leading role in reducing health inequalities, particularly for NCDs, in Slovenia.** In particular, PHC services together with public health services reaching out to communities has proved to be a powerful vehicle to reach vulnerable groups.
- **A contextualized community-based approach enables a prompt and structured response to the needs of vulnerable populations.** It increases social cohesion using formal and non-formal types of care and by combining population and individual approaches. It allows a combination of top-down and bottom-up approaches in developing and delivering programmes for those in need and goes beyond institutional boundaries in health and social care.
- **An integrated multidisciplinary approach requires transforming service delivery so governance, funding and competencies are aligned.** PHC, through HPCs, have an important role to play in delivering preventive services and public health programmes that focus on vulnerable groups within the community. However, coordination structures, sustainable financing and a competent workforce are crucial to perform these functions and assure integration of different services.

- **Multidisciplinary teams in HPCs have a broad spectrum of competencies and skills to provide health promotion and disease prevention programmes within PHC.** To successfully work with other sectors in the community and to address the needs of vulnerable populations, development of specific training materials and guidelines is needed. Over time, these multidisciplinary training approaches need to be integrated into mainstream public health, health promotion, primary care training and beyond the health sector into public policy and training for public administration.
- **Cross-sectoral cooperation based on a community-based approach is of crucial importance for health equity.** Local communities with a variety of stakeholders have enormous potential in mobilizing individuals and organizations to identify and include those left behind and contribute to a healthy environment and healthy choices for all.
- **Assuring sustainable financing for health promotion and disease prevention is crucial.** Involving key stakeholders from the start, in particular the payer and local authorities, is essential. Developing a local strategy and action plan, applying criteria to measure outcomes and reporting to the public and decision-makers on the progress and the impact of adopted measures can contribute significantly to the sustainability of equity-based preventive programmes.

References

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